



U.S. Department of Health and Human Services
Office of Inspector General

**Care Provider
Facilities Described
Challenges
Addressing Mental
Health Needs of
Children in HHS
Custody**

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Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody

Facilities that care for children in the Office of Refugee Resettlement's (ORR's) custody face the difficult task of addressing the mental health needs of all the children in their care, including children who have experienced intense trauma. According to those who treat them, many children enter the facilities after fleeing violence and experiencing direct threats to their safety during their journey to the United States. Some children also experienced the trauma of being unexpectedly separated from their parents as a result of U.S. immigration policies. Facilities must promptly address children's mental health needs—not only to stabilize each child in crisis, but also to reduce the risk that the child will negatively influence or harm others.

Key Takeaway

Facilities struggled to address the mental health needs of children who had experienced intense trauma and had difficulty accessing specialized treatment for children who needed it.

What OIG Found

Facilities described the challenges inherent in addressing the mental health needs of children who had experienced significant trauma before coming into HHS care. Facilities reported that challenges employing mental health clinicians resulted in high caseloads and limited their effectiveness in addressing children's needs. Facilities also reported challenges accessing external mental health providers and transferring children to facilities within ORR's network that provide specialized treatment. Policy changes in 2018 exacerbated these concerns, as they resulted in longer stays in ORR custody and a rapid increase in the number of younger children—many of whom had been separated from their parents after entering the United States.

What OIG Recommends and How the Agency Responded

We make six recommendations for practical steps that ORR can take to assist facilities. ORR should provide facilities with evidence-based guidance on addressing trauma in short-term therapy. ORR should also develop strategies for overcoming obstacles to hiring and retaining qualified mental health clinicians and consider maximum caseloads for individual clinicians. Finally, ORR should address gaps in options for children who require more specialized treatment and take all reasonable steps to minimize the amount of time that children remain in custody. Specific recommendations are in the report. ACF concurred with all six of our recommendations.

Why OIG Did This Review

By law, ORR, which is within the Department of Health and Human Services, has custody of and must provide care for each unaccompanied child, including addressing their mental health needs. ORR-funded care provider facilities are required to provide counseling to children and arrange for more specialized mental health services, as needed. We conducted our fieldwork during a time when ORR was experiencing an influx of children. Our findings could inform the Unaccompanied Alien Children Program's preparation for future surges.

How OIG Did This Review

In August and September 2018, OIG conducted site visits at 45 ORR-funded facilities, nearly half of all facilities in ORR's network at the time. These facilities were purposively selected and may not represent the experiences of staff in all ORR-funded facilities.

This report relies primarily on data collected from interviews with: approximately 100 mental health clinicians who had regular interaction with children across the 45 facilities; medical coordinators in each of the 45 facilities; facility leadership in each of the 45 facilities, including the program director and lead mental health clinician; and the 28 ORR federal field specialists assigned to the 45 selected facilities. We conducted qualitative analysis to identify the most significant challenges that facilities faced in addressing the mental health needs of children in ORR custody. This report does not determine whether challenges resulted in care that failed to meet ORR requirements, nor does it assess the quality or appropriateness of mental health care provided to children.

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BACKGROUND

Objective

To identify challenges that care provider facilities faced in addressing children's mental health needs.

The Department of Health and Human Services (HHS), Office of Refugee Resettlement (ORR), is the legal custodian of unaccompanied alien children (UAC) in its care. In this role, ORR is responsible for providing for the needs of these children, including addressing their mental health needs. For example, a child may have experienced significant trauma or other adverse life experiences that warrant attention while a child is in ORR's custody.¹ To address the needs of the children in its custody, ORR enters into grants or contracts with care provider facilities (facilities) to house and care for the children. These facilities provide counseling to children and arrange for more specialized mental health services, as needed. Any significant challenges that facilities face in addressing mental health needs could have serious immediate and long-term ramifications for children's well-being.

Background

Unaccompanied Alien Children Program

ORR, a program office of the Administration for Children and Families (ACF) within HHS, manages the UAC Program. UAC are minors who have no lawful immigration status in the United States and do not have a parent or legal guardian available to provide care and physical custody.² The UAC Program serves children who arrive in the United States unaccompanied, as well as children who, after entering the country, are separated from their parents or legal guardians by immigration authorities within the Department of Homeland Security (DHS). A child remains in ORR custody until an appropriate sponsor, usually a parent or close relative, is located who can assume custody.³ Children also leave ORR custody when they turn 18 and "age out" of the UAC Program, or when their immigration status is resolved.⁴ In Federal fiscal year 2018, the UAC Program received appropriations of \$1.6 billion and cared for at least 49,100 children.⁵ About 12,400 children were in the UAC Program at the time of our review.⁶

Care Provider Facilities

ORR funds a network of more than 100 facilities that furnish care for children until they are released to a sponsor or otherwise leave ORR custody. These facilities, generally, are State-licensed and must meet ORR requirements. Facilities provide housing, food, medical care, mental health services, educational services, and recreational activities.

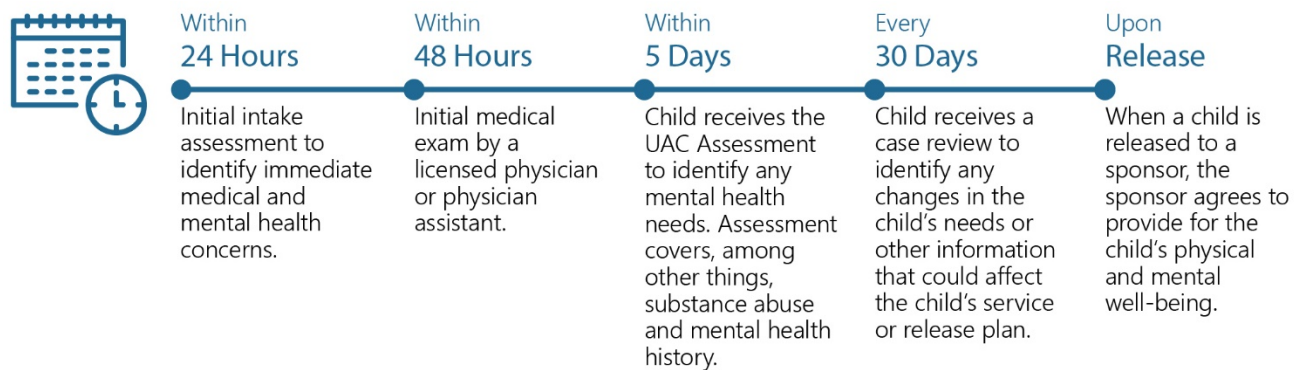
Federal law requires the safe and timely placement of children in the least restrictive setting that is in the best interest of the child.⁷ To that end, ORR has several different types of facilities in its network that provide different levels of care. Shelter facilities represent the least restrictive setting for children and comprise the majority of ORR's network. ORR's network includes two residential treatment centers (RTCs) that provide therapeutic care and services that can be customized to individual needs through a structured, 24-hour-a-day program. RTC placements are intended for children with mental health needs that cannot be addressed in an outpatient setting.⁸ Additionally, ORR's network includes nine staff secure facilities, including one that provides therapeutic care in combination with a higher level of security. ORR also funds two secure facilities that operate within existing juvenile detention facilities. See Appendix A for a complete list of the facility types that the Office of Inspector General (OIG) visited and their descriptions.

Required Mental Health Services in Care Provider Facilities

According to the terms of the 1997 *Flores* Settlement Agreement, which sets national standards regarding the detention, release, and treatment of children without legal immigration status in Federal custody, children must receive necessary medical and mental health services.⁹ Within 24 hours of the child's admission, facility staff must perform an initial intake assessment to identify, among other things, any immediate medical or mental health concerns that may require prompt intervention.¹⁰ Within 5 days of arrival, a child must also undergo a UAC assessment to more fully examine the child's mental health history and concerns. This assessment forms the basis of the child's service plan.¹¹

At a minimum, each child in ORR custody must receive at least one individual counseling session per week from a trained mental health clinician. The objective is to review the child's progress, establish new short-term objectives, and address both the developmental and crisis-related needs of the child. Additionally, facilities must provide children at least two group sessions per week, which allow staff and children to discuss whatever is on their minds and to resolve problems. Facilities also must ensure that children receive emergency health services, prescribed medications, and appropriate mental health interventions.¹² Exhibit 1 describes the mental health assessments and care that facilities must provide.

Exhibit 1: Facilities are required to provide mental health services throughout a child's time in care provider facilities



Source: OIG analysis of *ORR Guide: Children Entering the United States Unaccompanied*

At times, the number of children referred to ORR surges, and as a result, ORR uses temporary “influx” facilities to provide short-term care. ORR does not require that these influx facilities provide the same level of mental health care services as do other facilities. Specifically, influx care facilities are not required to provide ongoing individual and group counseling services.¹³

Providers of Mental Health Services

Children in ORR’s custody receive mental health services in two ways. Every child receives care from in-house mental health clinicians. When needed, children also may receive care from external mental health care providers, such as psychiatrists and psychologists.

In-house Mental Health Providers. Mental health clinicians are employed at every facility and are responsible for providing in-house mental health care for children. ORR requires that each facility employ at least 1 mental health clinician for every 12 children in care, although individual mental health clinicians could be responsible for more than 12 children.¹⁴ These in-house mental health clinicians are responsible for conducting mental health assessments, providing counseling services, providing crisis intervention services, and recommending care from external providers.

ORR requires that mental health clinicians have a master’s degree in psychology, sociology, social work, or another behavioral science requiring direct clinical experience, or a bachelor’s degree plus 5 years of clinical employment experience.¹⁵ Additionally, all mental health clinicians must be licensed or eligible for licensure. Lead mental health clinicians are responsible for coordinating facilities’ mental health services, training new mental health clinicians, and supervising the mental health clinical staff. They must have at least 2 years of post-graduate service-delivery experience, supervisory experience, and be licensed to provide mental health clinical services in the State where the facility is located.¹⁶

Other facility staff who may participate in coordinating or providing mental health care include medical coordinators and specialists employed by some facilities. Medical coordinators arrange care from external providers and coordinate other services related to children's medical and mental health care, including managing medications.¹⁷ See Appendix B for more information about other facility staff.

External Mental Health Providers. In addition to in-house staff, facilities can access external mental health providers through an insurance company (insurer) that ORR uses to authorize and coordinate reimbursement of these external services. The insurer maintains a network of doctors, hospitals, and other health professionals to provide mental health services to children in ORR custody. Facilities typically rely on external providers to prescribe psychotropic medications when warranted; in most States, such medications must be prescribed by certain types of licensed professionals, such as physicians or psychiatric nurse practitioners, who are not generally on staff.

Federal Policy Changes Affecting Care Provider Facilities

In 2018, facilities were addressing the mental health needs of a changing population of children, including younger children and those who had been separated from their parents, in part due to changes in immigration policies. As a consequence of heightened immigration enforcement beginning in 2017, DHS separated many more migrant families at the border, with the adults being held in Federal criminal detention facilities and their minor children—now “unaccompanied”—transferred to ORR's care.¹⁸ This policy, deemed “zero-tolerance” and formally adopted in May 2018, was curtailed in June 2018 by Executive Order and by order of the presiding judge in *Ms. L v. ICE*, a class action lawsuit.¹⁹ By that time, thousands of families had been separated.²⁰

ORR's specific requirements for screening potential sponsors has varied over time, as ORR balanced safety concerns with the need for the timely release of children from HHS custody. For example, before June 2018, ORR required all potential sponsors who were not parents or legal guardians of the child to submit fingerprints for processing by the Federal Bureau of Investigation (FBI). Parents or legal guardians (who comprise a large percentage of sponsors) and adult household members were required to submit fingerprints only in specific circumstances, such as when there was a documented risk to the safety of the child. However, in June 2018, ORR began requiring all parents or legal guardians and adult members of their households to submit fingerprints for FBI criminal history checks before a child could be released to that parent or legal guardian. According to ORR, this policy change was intended to better protect children from human trafficking and other exploitation; however, it also increased the number of fingerprints being submitted and their processing time, which delayed children's release from facilities.²¹ Along with this change, ORR also began sharing with Immigration and Customs Enforcement (ICE) the identifying

information and fingerprints of all potential sponsors and adult household members.²² Until February 2019, this information could be used for immigration enforcement purposes, which also may have discouraged potential sponsors from coming forward.²³

OIG Oversight Efforts

Since responsibility for the UAC Program was transferred to HHS by the Homeland Security Act of 2002, OIG has provided ongoing oversight of the Program. OIG has examined various aspects of the Program, including whether ORR grantees met safety standards for the care and release of children in their custody, and the efforts of ORR to ensure the safety and well-being of children after their release to sponsors. OIG issued several reports that made recommendations to address issues we identified. See Appendix C for a list of the related reports issued by OIG.

In 2018, OIG intensified its oversight of the UAC Program related to child health and safety in care provider facilities. Given the seriousness of the concerns about the treatment of children in ORR custody, including children who had been separated from their parents, OIG completed a large, multifaceted review of the UAC Program focused on the health and safety of children in HHS's care. The review gathered information from facilities across the country, including information from facility management, staff responsible for caring for the children, and ORR federal field specialists who help to oversee individual facilities.

This report is focused on the challenges that facility-interviewees reported in providing mental health care. Another OIG report addresses background screening of the facility employees who have direct contact with children.²⁴ Other reports will address child safety, facility security, and family reunification.

Methodology

Scope. To meet our objective to identify challenges that facilities faced in addressing children's mental health needs, OIG conducted site visits at 45 of the 102 ORR-funded facilities that were in operation across the country at the time of our review. All site visits lasted 2 or 3 days and occurred in August and September 2018, with the majority in August.

We visited facilities to learn about the challenges that they faced in addressing children's mental health needs. We interviewed key personnel about the challenges that made providing mental health care more complicated. We did not gather data to determine whether these challenges resulted in care that failed to meet ORR requirements. We did not assess the quality or appropriateness of mental health care provided to the children.

We conducted our fieldwork during a time when ORR was experiencing a rapidly expanding population of new groups of children in its custody. This timing allowed us to understand challenges related to addressing the

mental health needs of separated children and younger children, in addition to challenges associated with seasonal influxes of children transferred to ORR care.

Selection of facilities. We used a purposive selection process to achieve wide coverage of facilities participating in the UAC Program. In order to ensure a diverse set of facilities, our selection included facilities that:

- varied in size,
- operated in different geographic locations,
- operated as shelters or as specialty facilities,
- cared for children of varying ages, and
- cared for separated children.

The 45 visited sites included facilities that cared for 72 percent of the children in ORR custody at the time of our review. We visited 19 of the largest facilities in ORR's network. Of the facilities that we visited, about two-thirds (28) were shelter facilities, the most common type of facility in ORR's network. We also visited every RTC (2), staff secure (9), secure (2), and influx (2) facility in ORR's network at the time. Most facilities (29 of the 45) cared only for teenagers, but we also visited 16 facilities that cared for younger children. Additionally, 37 facilities that we visited cared for at least one child who had been separated from a parent after entering the United States. See Appendix A for more information about the facilities that we visited.

Data Collection

Facility site visits. Multi-disciplinary teams of OIG staff conducted each site visit. Each team consisted of at least one evaluator, auditor, investigator, and attorney. These teams were trained in advance regarding their responsibilities specific to this fieldwork. Onsite activities included, among other things, interviewing key facility personnel, examining facility employee records, and conducting structured assessments of facility premises.

This report focuses on challenges that facilities reported in addressing the mental health needs of children in their care, and relies primarily on discussions with:

- approximately 100 mental health clinicians who had regular interaction with children across the 45 facilities;²⁵
- medical coordinators in each of the 45 facilities;
- facility leadership in each of the 45 facilities, including the program director and lead mental health clinician;²⁶ and
- the 28 ORR federal field specialists assigned to the 45 selected facilities.²⁷

Combined, these were the key personnel who provided and coordinated mental health care, and those responsible for facility operations and oversight, at the time of our visits.

Key personnel interviews. We interviewed key personnel in private using standardized interview protocols. Each protocol included a variety of questions intended to help us learn more about how facilities address children's mental health needs and any challenges they face in doing so.

- *Program directors* responded to a series of questions about children's mental health needs, the care they received from in-house staff and external providers and challenges their facilities faced meeting children's needs. Program directors also discussed their facilities' recruiting and staffing.
- *Lead mental health clinicians* responded to a series of questions about the mental health needs of the children in their care, the type of mental health care provided both in-house and from external providers, challenges they faced in addressing the mental health needs of children, and any concerns they had about children's mental health treatment, including psychotropic medications.
- *Medical coordinators* responded to questions about coordinating care with external providers and managing medications, including psychotropic medications.

Case discussions with mental health clinicians. To better understand the nature of facility challenges, we discussed the mental health care of three specific children at each facility. Facility staff selected up to three cases for discussion; OIG requested that they choose:

- one case representing mental health issues the facility saw frequently,
- one case representing an example of the most serious mental health issues the facility faced and,
- where available, one case representing a child who had been separated from a parent after arrival in the United States.

For each case, the mental health clinician assigned to the child discussed the case with OIG staff while referencing the case file. We completed 123 case discussions with 96 mental health clinicians. The case discussions helped to inform our understanding through real-world examples of challenges that mental health clinicians encountered. OIG staff did not independently review individual children's health records or services as a part of these discussions, nor did we assess the quality or appropriateness of mental health care provided to the children.

ORR federal field specialist interviews. In the weeks following the site visits, OIG staff interviewed the 28 ORR federal field specialists who worked directly with each of the 45 selected facilities. During these interviews, we gathered information and insights from ORR federal field specialists about challenges and concerns with how facilities addressed the mental health needs of children in their care.

ORR data and policies and procedures. We reviewed ORR data, and policies and procedures concerning mental health care. We reviewed information about bed capacity and availability at each facility in the ORR network as of August 31, 2018. We collected and reviewed ORR policies and procedures for facility transfers, and processes for authorizing and reimbursing care provided by external specialists. We also interviewed ORR headquarters staff to clarify other policies and procedures related to mental health services.

Analysis

We performed qualitative analysis of the interviews conducted during the site visits. The analysis identified themes related to challenges in addressing the mental health needs of children in ORR's custody. We aimed to identify the most significant challenges impacting mental health care, as reported by facility staff and ORR federal field specialists. A challenge was considered significant if it was identified by multiple staff across multiple facilities. As such, the report does not reflect every challenge that facility staff mentioned during interviews.

Qualitative analysis involved multiple steps carried out by OIG staff. The analysis team used qualitative analysis software to organize interview responses related to mental health care and categorize themes that emerged. Results were examined to identify significant challenges reported by facility personnel and ORR federal field specialists. Additional quantitative analysis of ORR data focused on the number of younger children referred to ORR in 2018 and the average length of stay in ORR care from January 2018 to April 2019.

Limitations

The facilities that we visited were purposively selected and may not represent the experiences of staff in other facilities. We did not independently verify information provided by facility staff during interviews and did not reconcile conflicting information from different employees within a facility.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Care provider facilities described the inherent challenges of addressing the mental health needs of a population of children who had experienced significant trauma

Intense trauma was common among children who entered care provider facilities

Facility managers and mental health clinicians reported that many children who entered facilities in 2018 had experienced intense trauma from a variety of events before and upon their arrival in the United States.

In their countries of origin. According to mental health clinicians and program directors, some children had experienced physical or sexual abuse and other forms of violence while in their country of origin. Staff in multiple facilities reported cases of children who had been kidnapped or raped, some by members of gangs or drug cartels. In one case, a medical coordinator reported that a girl had been held in captivity for months, during which time she was tortured, raped, and became pregnant. Other children had witnessed the rape or murder of family members or were fleeing threats against their own lives. In one case, a mental health clinician reported that, after fleeing with his mother from an abusive father, the child witnessed the murder of his mother, grandmother, and uncle.

On their journey to the United States. According to mental health clinicians and program directors, some children experienced or witnessed violence during the trip to the U.S. border. For example, a mental health clinician in one facility shared the story of a child who, while attempting to cross from Guatemala to Mexico, was abducted by a gang and held for ransom. The gang held the child in a compound, where another individual was shot in the head. Later, a woman who helped the child escape from the compound was shot by the gang.

Once in the United States. According to mental health clinicians and program directors, some children experienced additional trauma after they arrived in the United States. Some children faced additional trauma when they were unexpectedly separated from a parent. Even for children who entered the United States without their parents—those not separated—some found it traumatic to adapt to new and unfamiliar situations in facilities. As one mental health clinician explained, adapting was difficult because children “lose friends, staff, the routine. And if they have to move somewhere else, it’s just one more loss.”

Mental health clinicians reported concerns about their ability to address children’s significant trauma

Given the level of intense trauma that children had experienced before coming into HHS care, mental health clinicians expressed concerns that they were not able to address the children’s mental health issues. In part, these concerns derived from the fact that mental health clinicians did not know how long a child would be in their facility. Many children had a relatively

short stay at a facility, from a treatment perspective, and the amount of time was often unpredictable. Given this uncertainty, mental health clinicians reported being wary of having children revisit traumatic incidents that they might not be able to address adequately through continued therapy. For example, mental health clinicians described intentionally not probing into past events, but instead staying focused on helping children to cope and remain stable. Mental health clinicians referred to this as a “Band-Aid” approach, akin to psychological first aid; the goal is not to treat children’s underlying issues because children will not be in the facility long enough to make meaningful progress.

Mental health clinicians expressed concerns about feeling unprepared to handle the level of trauma that some children presented, despite their prior training and experience. As detailed in a separate report, OIG found that virtually all mental health clinicians whose records we reviewed met established educational requirements.²⁸ Further, all facilities reported that they provided training for their staff—including mental health clinicians—to help them work with children who had experienced trauma. Nonetheless, mental health clinicians discussed how challenging it was to hear about children’s traumatic experiences, which sometimes caused the clinicians to become overwhelmed or suffer their own mental distress. Further, mental health clinicians said that colleagues hired without previous experience in caring for children in ORR custody may have been especially unprepared for the severe trauma of children in their care. Both program directors and mental health clinicians expressed that more training on trauma-informed care could be beneficial.

Addressing children’s mental health needs was especially challenging in 2018 due to an influx of separated children and longer stays in care provider facilities

Care provider facilities reported that separation from parents and a hectic reunification process added to the trauma that children had already experienced and put tremendous pressure on facility staff. Facilities reported that addressing the unique mental health needs of separated children was particularly challenging. According to program directors and mental health clinicians, separated children exhibited more fear, feelings of abandonment, and post-traumatic stress than did children who were not separated. Separated children experienced heightened feelings of anxiety and loss as a result of their unexpected separation from their parents after their arrival in the United States. For example, some separated children expressed acute grief that caused them to cry inconsolably.

Children who did not understand why they were separated from their parents suffered elevated levels of mental distress. For example, program directors and mental health clinicians reported that children who believed their parents had abandoned them were angry and confused. Other children expressed feelings of fear or guilt and became concerned for their parents’ welfare. The difficulties that some facilities had in locating parents

A 7- or 8-year-old boy was separated from his father, without any explanation as to why the separation occurred. The child was under the delusion that his father had been killed and believed that he would also be killed. This child ultimately required emergency psychiatric care to address his mental health distress.

–Program director

Physical symptoms felt by separated children are manifestations of their psychological pain. You get a lot of “my chest hurts,” even though everything is fine [medically]. Children describe symptoms, “Every heartbeat hurts,” “I can’t feel my heart,” of emotional pain.

–Medical director

in detention and scheduling phone calls also contributed to children’s anxiety and fear for their parents’ well-being.

The level of trauma and unique experiences of separated children made it more difficult to establish therapeutic relationships through which facilities could address children’s mental health needs. Program directors and mental health clinicians described challenges gaining the trust of separated children. For example, one program director noted that separated children could not distinguish facility staff from the immigration agents who separated them from their parents: “Every single separated kid has been terrified. We’re [seen as] the enemy.” Program directors and mental health clinicians also noted that some separated children isolated themselves and took longer to adjust to the facility and its routines, for example, refusing to eat or participate in activities.

Adding to the challenge of addressing the mental health needs of separated children was the uncertainty that came with a hectic reunification process for children covered by the *Ms. L v. ICE* lawsuit. This lawsuit established a different reunification process for *Ms. L* class members and their separated children, along with fixed court-imposed deadlines for family reunification. Program directors reported that the guidance that ORR provided to facilities in 2018 on how to carry out reunifications for children covered by the *Ms. L* case changed frequently and with little notice. Changing guidance resulted in uncertainty around how or when reunification would happen. For example, case managers in facilities were not always able to let children know when, or even if, they would be reunified with their parents, or whether that reunification would happen in the United States. This type of uncertainty added to the distress and mental health needs of separated children.

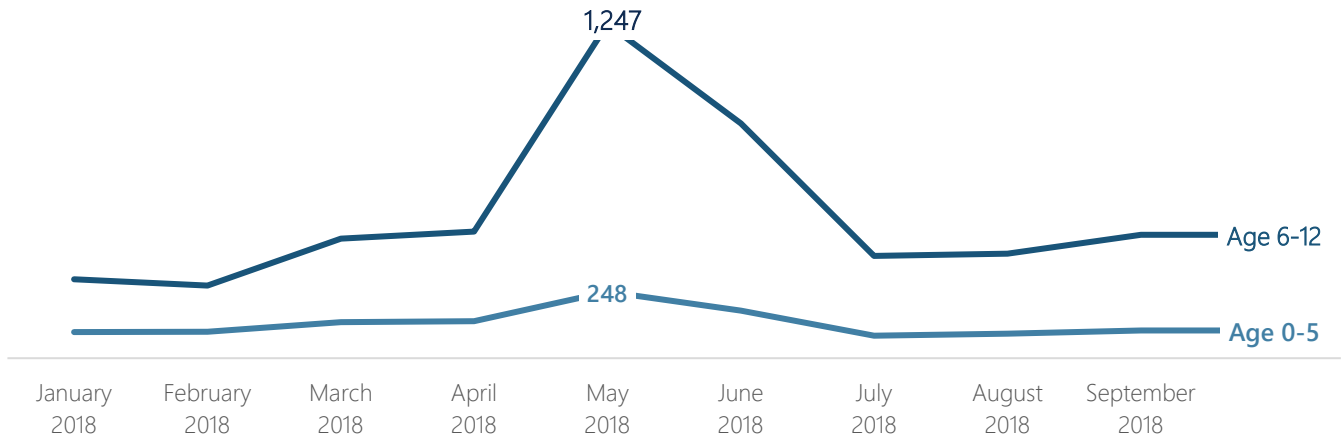
Even when they were prepared to reunify separated children covered by the *Ms. L* case with their parents, facilities reported that logistical issues introduced further uncertainty that could lead to emotional distress. Facilities reported that some reunifications were scheduled with little advance notice, or suddenly canceled or delayed, which increased the levels of uncertainty and anxiety in separated children and other children in the facility. In one case, a child was moved from a facility in Florida to a facility in Texas to be reunited with her father. However, a mental health clinician reported that after the child made several trips to the detention center, she was returned to the Florida facility “in shambles” without ever seeing her father.

Care provider facilities described challenges providing age-appropriate mental health services, especially when faced with an unexpected increase in children age 12 and younger

As shown in Exhibit 2, facilities cared for an increasing number of younger children in 2018. The number of young children, age 12 and younger, in

ORR's care increased sharply in May 2018 when DHS formally adopted the zero-tolerance policy of criminally prosecuting all adults for illegal entry into the United States. This policy led to children, some of them quite young, being separated from their parents. The proportion of young children in ORR care rose from 14 percent of referrals to ORR in April 2018 to 24 percent of referrals in May 2018.

Exhibit 2: The number of young children referred to ORR increased sharply in May 2018, when DHS formally adopted the “zero-tolerance” policy



Source: OIG Analysis of ORR referrals data.

The little ones don't know how to express what they are feeling, what has happened. Communication is limited and difficult. They need more attention.

—Program director

Faced with a sudden and dramatic increase in young children, staff reported feeling challenged to care for children who presented different needs from the teenagers they typically served. Facilities noted that elementary-school-aged children had shorter attention spans, lacked the ability to comprehend the role of the facility, and more commonly exhibited defiance and other negative behaviors. Facilities noted the difficulties associated with completing assessments and other screenings for pre-school aged and younger children who could not accurately communicate their background information, needs, or the source of any distress.

Care provider facilities reported that longer lengths of stay resulted in deteriorating mental health for some children and increased demands on staff

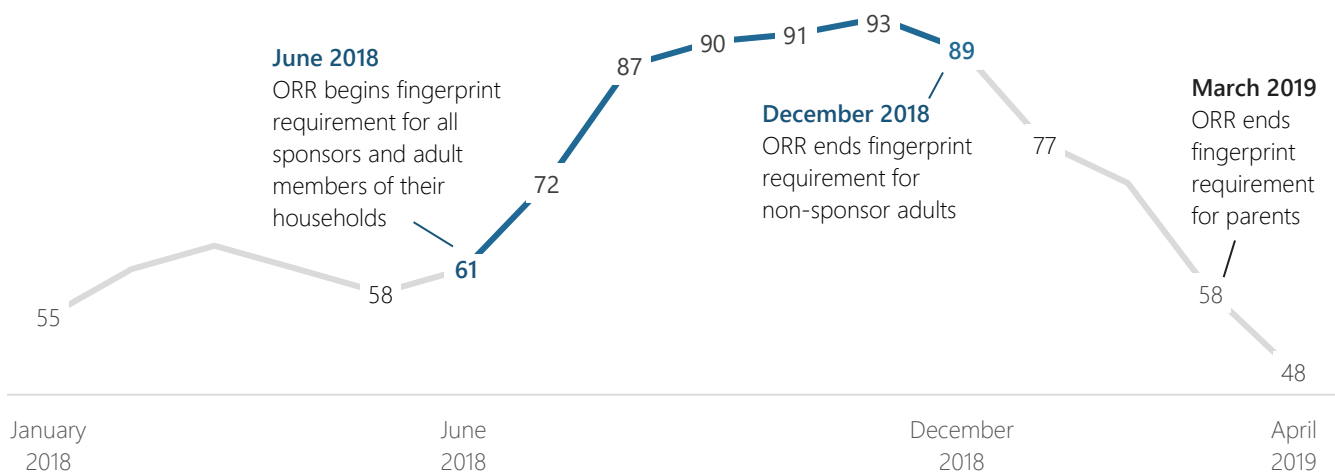
Facilities reported that children with longer stays experienced more stress, anxiety, and behavioral issues, which staff had to manage. Some children who did not initially exhibit mental health or behavioral issues began reacting negatively as their stays grew longer. For example, one mental health clinician explained that even children who were outgoing and personable started getting more frustrated and concerned about their cases around the 70th day in care. According to facility staff, longer stays resulted in higher levels of defiance, hopelessness, and frustration among children, along with more instances of self-harm and suicidal ideation. One mental

health clinician, for example, remarked that even children who come into care with good coping skills become disillusioned after a lengthy stay. Facilities also reported that children who had arrived in the United States on their own felt a sense of frustration in the summer of 2018 as they witnessed the expedited reunification of separated children, while seeing little movement in their own cases.

Facilities attributed longer stays for children to ORR's new sponsor screening requirements. As mentioned earlier, in June 2018, ORR revised its sponsor screening requirements and began mandating fingerprint-based FBI criminal history checks of all potential sponsors, including parents, and all adult members of their households.²⁹ Further, these fingerprints were shared with ICE and could be used for immigration enforcement purposes.³⁰ Facilities reported that it became more difficult to identify sponsors willing to accept children after the new fingerprinting requirements were implemented, which delayed placing children with sponsors, adding further stress and uncertainty.

As shown in Exhibit 3, children's average length of stay in ORR custody increased markedly after ORR implemented the new fingerprinting policy in June 2018. The average length of stay reached a high of 93 days for children who were released from ORR custody in November 2018. The average length of stay that children spent in ORR's custody began to decline after December 2018, when ORR ended the requirement for fingerprint background checks for all non-sponsor adult members of households. In March 2019, ORR further modified its policy, ending fingerprint background checks for parents or legal guardians, in most circumstances. By April 2019, the average length of stay had declined to 48 days.

Exhibit 3: In June 2018, ORR began requiring fingerprint background checks of all potential sponsors and adult members of their households, which affected the average number of days children spent in ORR care



Source: OIG Analysis of ORR data.

Care provider facilities reported high caseloads due to challenges recruiting and retaining mental health clinicians

The most challenging thing is the lack of time due to the caseloads. Our concern is always whether the quality of therapy suffers... Some [children] have behavioral issues or are going through difficult times and you need to see them more during a given period. It becomes a strain on us.

—Lead mental health clinician

Mental health clinicians expressed that high caseloads limited their effectiveness in addressing children's needs. ORR's required facility-wide staffing ratio is 1 mental health clinician for every 12 children. However, facilities reported that some individual mental health clinicians managed caseloads of more than 25 children. According to mental health clinicians, high caseloads hurt their ability to build rapport with children and allowed less time for counseling. They also reported facing challenges when trying to provide longer or more frequent counseling sessions to children with greater needs, while also attempting to ensure that other children assigned to them received enough attention.

Clinician rotations addressed some challenges and introduced others

One grantee rotated mental health clinicians among five facilities for short-term assignments in response to mental health clinician shortages. However, mental health clinicians at these facilities believed that rotations disrupted clinical relationships with the children and inhibited therapeutic progress. Together, the facilities cared for more than 2,500 children at the time of our site visits.

High caseloads largely resulted from facilities' challenges hiring and retaining mental health clinicians. Program directors reported difficulties in finding qualified candidates, especially those who were fluent in the languages spoken by children in their care.³¹ Program directors explained that these challenges were heightened for facilities in remote or rural areas, reflecting a shortage of mental health professionals in certain geographic regions.³² Further, program directors also reported experiencing challenges with retaining mental health clinicians because of low compensation, demanding work schedules, and competing job opportunities. These challenges made it difficult for facilities to retain staff even in urban centers with more potential candidates.

Care provider facilities faced challenges accessing external specialists

Program directors, medical coordinators, and mental health clinicians noted that they had difficulty accessing external mental health specialists. Although a few facilities (4 of the 45 that we visited) employed a mental health specialist, such as a psychiatrist, psychologist or psychiatric nurse practitioner, most facilities turned to external specialists when in-house mental health clinicians could not meet the mental health needs of a child.³³ To help facilities access needed specialists, ORR officials reported that its healthcare insurer maintains agreements with several geographically dispersed, licensed healthcare providers to serve children.

Nonetheless, facilities reported challenges accessing these external mental health specialists. For example, some facilities were in underserved areas with relatively few practicing specialists. Mental health clinicians and an ORR federal field specialist also expressed their concerns that specialists hesitated to continue treatment of children, or initiate new treatment,

As the population in the area grows, the existing providers get more saturated with work, so it becomes more difficult to get appointments... We need more psychiatrists, neurodevelopmental psychiatrists, and psychologists.

—Program director

Care provider facilities reported challenges transferring and caring for children who needed specialized treatment

The facility tries to keep them safe, but there are many ways a child can harm themselves. The children need a secure residential treatment center for children that are high-risk and need intensive therapy.

—Lead mental health clinician

because prior reimbursements had been late. Complicating matters, facilities reported that those specialists who were available often were not fluent in the languages spoken by the children or familiar with their cultural backgrounds. For example, one medical coordinator noted that the only bilingual psychologist in its network was in a neighboring State.

Children experienced treatment delays when they could not access external specialists. Mental health clinicians and program directors reported long waits for mental health evaluations and treatment from external specialists and other providers. Staff described making appointments with psychiatrists and psychologists for dates that were 2 or 3 months away. To help address the limited access to in-person specialists, some facilities reported using telemedicine to access psychiatrists remotely. For example, a facility in an underserved area reported using telehealth appointments to fill the gaps when they encountered difficulty finding local psychiatrists.

Care provider facilities reported challenges transferring children to RTCs

When mental health clinicians determined that children needed a higher level of care, facilities reported difficulties transferring those children to facilities in the ORR network that are licensed to provide specialized care.³⁴ At the time of our review, two RTCs, with a total capacity for 50 children, were available in ORR's network. Facilities reported that they were sometimes unable to transfer children with significant mental health needs to RTCs because the RTCs were at capacity or had waiting lists.

To supplement these two in-network RTCs, ORR sometimes refers children to out-of-network RTC providers with which ORR contracts. These are used in situations when the services provided by the two in-network RTCs are not appropriate to address a child's unique needs or because there is not ample bed space in network. As of September 1, 2018, at the time of our review, ORR reported that four children were in these placements.³⁵

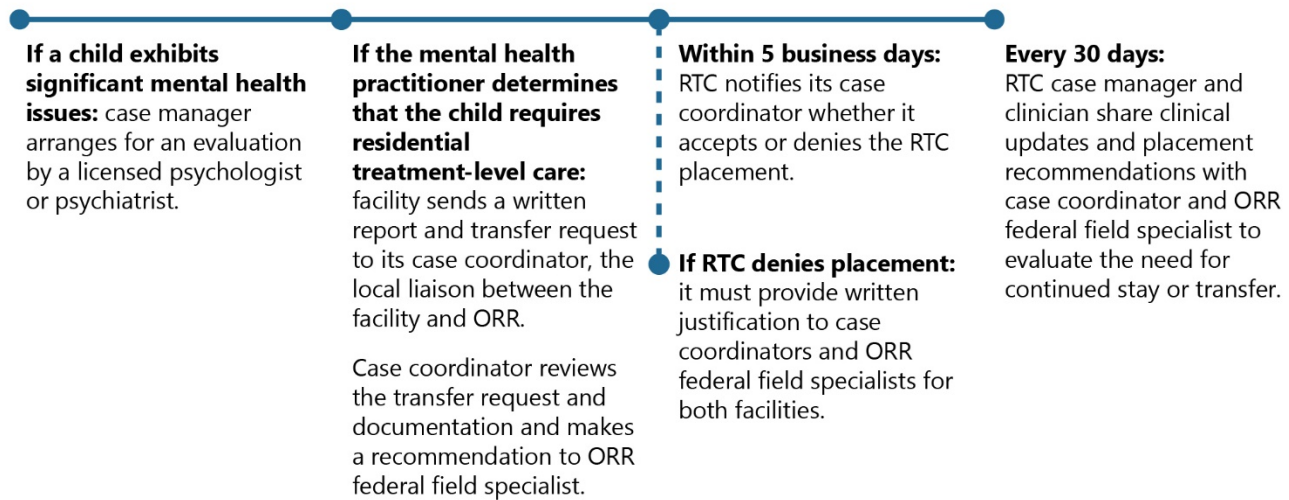
Program directors and mental health clinicians also expressed concerns about the lack of therapeutic placement options for children whom they diagnose as needing a higher level of mental health care, but who also have a history of behavior problems. Facilities reported that the RTCs in ORR's network of facilities do not accept aggressive children. According to mental health clinicians, this limited options for children who exhibited aggressive behaviors or were considered a runaway risk. For example, one mental health clinician noted challenges finding an appropriate placement for a child diagnosed with bipolar disorder, who was also physically aggressive. Facilities noted that sometimes a child's troublesome behavior resulted from underlying mental health issues that required more intensive treatment to resolve.

Although ORR's network includes one 16-bed therapeutic staff secure facility that provides intensive mental health services and a higher level of security,

this facility alone did not meet the demand. During an interview in March 2019, ORR officials described efforts to add new facilities that provide therapeutic care in more secure settings.

Facilities also mentioned difficulty obtaining the needed medical recommendation in a timely manner as another obstacle to transferring children to RTCs. As shown in Exhibit 4, to ensure that higher-level therapeutic care is warranted, ORR requires that a licensed psychologist or psychiatrist provides a recommendation for the transfer.³⁶ Facilities explained that they were not always able to get timely transfer recommendations, in part because of the difficulty scheduling appointments with external mental health specialists. One program director noted that an external psychiatrist often wanted several followup visits with a child before making a transfer recommendation.

Exhibit 4: Care provider facilities must receive a recommendation from a mental health specialist before transferring a child to an RTC



Source: OIG Analysis of *UAC Manual of Procedures*.

Facilities reported negative consequences of caring for children whom they judged should be transferred to another setting

Program directors and mental health clinicians reported safety concerns when children whom staff assessed as needing a higher level of mental health care were not transferred to RTCs. As a result, they reported that some children with more significant mental health needs—such as oppositional defiant disorder, dissociative symptoms, and suicidal ideation—remained in settings not well equipped to address their needs. Facilities noted that children who did not receive requested transfers to RTCs displayed behaviors that put themselves and others at risk. For example, one program director described caring for children who were

The staff [in a shelter facility] end up brainstorming on how to provide mental health services to kids, but that's not what the facility is designed for. It is a temporary shelter, not a treatment facility. There is also an issue where residential treatment facilities won't take minors who are aggressive, even when those minors are aggressive because they have untreated mental trauma.

–Program director

psychotic, self-harming, or actively attempting suicide. Another described a child whose self-harm and aggressive behavior continued while awaiting transfer to an RTC.

Facilities also reported that children who needed higher levels of mental health treatment consumed more attention, leaving less capacity to address the other children in the facility. One mental health clinician noted that a child who was denied admission to an RTC because of prior runaway attempts, “consumed most of my time from December to July.” Another mental health clinician reported that managing a difficult case made it more challenging to fit in other children’s scheduled counseling appointments because they were frequently called away to de-escalate situations.

CONCLUSION AND RECOMMENDATIONS

Facilities that care for children in ORR custody face the difficult task of addressing the mental health needs of all children in their care, including the needs of those who have experienced significant trauma. According to those who care for them, many children enter the facilities after fleeing violence or experiencing direct threats to their safety during their journey to this country. In 2018, some children also experienced the trauma of being unexpectedly separated from their parents as a result of U.S. immigration policies. Promptly addressing children's mental health needs is essential—not only to stabilize each child in crisis, but also to minimize the risk the child may negatively influence or harm others.

Facilities reported challenges addressing the individual mental health needs of children in ORR's custody. Facilities reported challenges employing in-house mental health clinicians and preparing them to treat children in crisis, accessing external providers to treat children who needed higher levels of mental health care, and transferring children to facilities that can provide needed specialized care. Exacerbating these concerns, policy changes in 2018 resulted in increases in the length of time that children stayed in ORR custody and a rapid increase in the number of children under the age of 12—many of whom had been separated from their parents after entering the United States.

This report provides ORR with information from the field, useful for directing attention toward the most significant mental health-related challenges facing facilities.

The following six recommendations represent practical steps ORR can take to assist facilities in addressing the mental health care of children in its custody. Across many of these recommendations, we encourage ORR to consult or partner with subject matter experts who can assist ORR in making improvements. Such experts may be available within HHS and have contacts with the broader mental health community.

We recommend that ORR:

Identify and disseminate evidence-based approaches to addressing trauma in short-term therapy

ORR should work with subject matter experts to identify and disseminate additional tools to help clinical staff address trauma in children. Mental health clinicians expressed concerns about feeling unprepared to handle the level of trauma that some children presented, despite their prior training and experience, especially in short-term therapy.

ORR should identify or create resources that can improve facilities' readiness to meet the mental health care needs of children of all ages, including very

young children and pre- or non-verbal children. ORR also could establish and make available a technical assistance group composed of subject matter experts, which could help to ensure that facilities' treatment reflects current best practices. This group could serve as a resource to facility mental health clinicians when they have questions or need help treating children in their care. ORR has already committed resources to addressing children's mental health by employing a clinical child and adolescent psychiatrist and a psychiatric nurse practitioner to support the UAC Program.

Develop and implement strategies to assist care provider facilities in overcoming obstacles to hiring and retaining qualified mental health clinicians

Facilities' challenges hiring and retaining mental health clinicians affect their ability to meet ORR's required staffing ratios, which are designed to ensure facilities can meet children's mental health needs. As one possible strategy, ORR could assist facilities with regional recruitment efforts, such as outreach to universities with clinical programs to raise awareness of the UAC Program and possible job opportunities.

ORR should also evaluate whether using telemedicine to access remote psychiatry and psychology services is an effective way to bridge the gap when facilities cannot access external providers in person. Facilities reported that, while not a perfect replacement for in-person care, access to these services allowed children to receive necessary treatment and helped to limit delays in care.

ORR also could consider entering agreements with governmental and non-governmental entities that could dispatch mental health clinicians to fill vacancies to address facilities' needs. These efforts could help release the time and workload pressures that contribute to mental health clinician staffing issues and could improve their ability to address children's needs.

Assess whether to establish maximum caseloads for individual mental health clinicians

Although ORR already requires facilities to maintain an overall facility-wide ratio of at least 1 mental health clinician employed for every 12 children in care, facilities sometimes assign large caseloads to individual clinicians. However, according to some mental health clinicians, such high caseloads limited their availability and effectiveness. ORR could consult with subject matter experts to determine an appropriate maximum caseload that would ensure mental health clinicians are able to meet the needs of children and adjust grant and contract requirements, as appropriate.

Help care provider facilities improve their access to mental health specialists

ORR should ensure that its national network of external healthcare providers includes the mental health specialists needed to address children's mental health needs. ORR should determine whether the provider networks maintained by ORR's insurance underwriter include providers operating in a full range of specialties and sub-specialties, with needed language skills, in locations where ORR-funded facilities operate. Facility staff reported that limited access to external providers resulted in delays in treatment and transfers. Ensuring access to necessary mental health care will help facilities meet children's mental health needs and limit the chance that they will become a risk to themselves or others.

For facilities in areas with a scarcity of mental health specialists, ORR could consider entering into agreements with Federal, State, or local health agencies or qualified specialists to provide necessary mental health treatment. ORR could work with HHS agencies and subject matter experts, such as the Administration for Community Living, to explore strategies and resources.

Increase therapeutic placement options for children who require more intensive mental health treatment

ORR should follow through with its plans to expand placements in its network for children with the most significant mental health needs. In particular, ORR should ensure that its network has sufficient options for children with both disruptive behavioral and significant mental health issues. During our site visits, program directors, mental health clinicians, and ORR federal field specialists highlighted the need for more therapeutic placements available in the ORR network for children who are identified as needing specialized treatment.

In addition, on an ongoing basis, ORR should assess its capacity to ensure that the availability of beds reflects the diversity of behavioral and mental health needs of children in its care. Moving forward, ORR should consult with subject matter experts about the types of therapeutic facilities that can meet children's needs in the least restrictive setting.

Take all reasonable steps to minimize the time that children remain in ORR custody

Mental health clinicians described that a child's mental health often deteriorates as the length of their stay in ORR custody increases. ORR should continue to make reasonable policy and practice decisions that can help to minimize the length of stay for children in ORR facilities. It is also essential that ORR appropriately assesses all sponsors before making a release determination, to ensure a child's safety after their release from ORR custody. OIG recognizes these constraints and does not suggest that ORR relax its sponsor screening requirements.

In addition, ORR should assess current policies and procedures to ensure that they do not present unnecessary barriers to children's release to appropriate sponsors and adjust, as appropriate. Lastly, ORR should establish procedures to ensure that future policy changes prioritize child welfare considerations and do not inadvertently increase the length of time a child remains in ORR custody.

AGENCY COMMENTS AND OIG RESPONSE

ACF concurred with all of our recommendations.

In concurring with the first, second, third, and sixth recommendations, ACF described its plans to address them, some of which are underway. ACF reported that ORR has hired a board-certified psychiatrist to serve as team leader working to improve ORR's mental health care services. ACF also reports engaging with experts in trauma-informed care to create a webinar to train facility staff in the unique mental health needs of children in HHS custody. ACF anticipates beginning the webinars in August 2019. ACF also committed to assisting facilities in hiring and retaining qualified mental health clinicians and assessing the size of clinician caseloads to ensure quality mental health care for children in ORR care. Additionally, ACF described policy changes that it has implemented to minimize the time that children remain in ORR custody and stated this it is required to submit a plan to Congress for improving the rate at which it discharges children.

Although ACF concurred with our fourth recommendation, it did not specify new actions it plans to take to improve access to external mental health specialists. We encourage ACF to expand its efforts to identify appropriate mental health specialists and look forward to learning more about ACF's efforts.

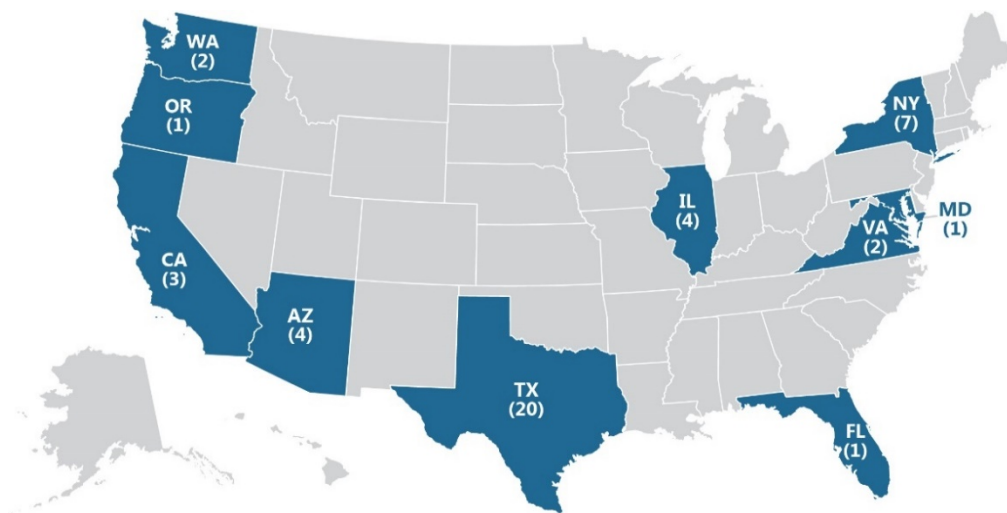
ACF concurred with our fifth recommendation and discussed the challenges it faces expanding the number of therapeutic placement options in ORR's network. We acknowledge these efforts and encourage ACF to continue its work to ensure that children who need higher levels of mental health care have access to the appropriate level of care.

One aspect of ACF's comments warrants correction. ACF stated that our qualitative analysis "corroborates that UAC generally received all legally-required mental health care." However, the report does not make such an assertion, because it was beyond the scope of our review to assess whether the mental health care provided in ORR-funded facilities met all legal requirements. Rather, the report identifies the most significant challenges that facilities faced in addressing the mental health needs of children in ORR custody.

For the full text of ACF's comments, see Appendix E.

APPENDIX A: Care Provider Facilities Visited by OIG

During August and September 2018, OIG staff conducted site visits to 45 facilities across 10 States.



Number and Type of Facilities Visited

28	Shelter	Most common type of residential care facility; provides housing, food, medical care, mental health and educational services, and recreational activities.
9	Staff Secure	Provides close supervision to children who exhibit disruptive behavior, are a flight risk, or display gang affiliation. This includes the only therapeutic staff secure facility that ORR funded at the time of our site visit, which provides a combination of close supervision and intensive support and clinical services (e.g., in-depth counseling).
2	Secure	Provides care for children who pose a danger to self or others, or who have been charged with a crime.
2	Residential Treatment Center	Provides children who need more intensive mental health treatment with sub-acute therapeutic care through a structured 24-hour-a-day program and services that are highly customized to individual needs.
2	Influx	Provides children with temporary emergency shelter and services; used when ORR experiences an influx of children.
2	Transitional Foster Care	Provides short-term foster care for children under age 13, siblings, pregnant and parenting teens, or those with special needs; services provided in the community.

Source: OIG analysis of ORR and facility data, 2019.

Facilities Visited

The table below lists and describes the 45 facilities that OIG visited.

Facility Name	Facility Type	Number of Children in Care*	Licensed to Care for Younger Children**	Cared for Separated Children***
Arizona (4)				
SWK Campbell	Shelter	126	•	•
SWK Casa Phoenix	Shelter	385		•
SWK Estrella	Shelter	295	•	•
SWK Hacienda del Sol	Shelter	139	•	•
California (3)				
BCFS Fairfield	Staff Secure	11		
SWK Pleasant Hill	Shelter	26		•
Yolo County	Secure	19		
Florida (1)				
Homestead	Influx	1,347		•
Illinois (4)				
Heartland CRC IRC	Shelter	193	•	•
Heartland Casa Guadalupe	Shelter	47	•	•
Heartland IYC	Staff Secure	6		
Heartland SCiy	Shelter	5		•
Maryland (1)				
Board of Child Care	Shelter	42	•	•
New York (7)				
Abbott House	Shelter	51	•	•
Cayuga Centers	Transitional Foster Care	609	•	•
Children's Village	Shelter	167		•
Children's Village	Staff Secure	26		
MercyFirst	Residential Treatment Center	9		•
Leake and Watts/ Rising Ground	Shelter	47		•
Lincoln Hall	Shelter	184		•
Oregon (1)				
Morrison Paso	Staff Secure	11		

(Continued on next page)

Facility Name	Facility Type	Number of Children in Care*	Licensed to Care for Younger Children**	Cared for Separated Children***
Texas (20)				
BCFS Baytown	Shelter	216	•	•
BCFS Harlingen	Shelter	576	•	•
BCFS Raymondville	Shelter	50	•	•
BCFS San Antonio	Shelter	110	•	•
BCFS San Antonio	Staff Secure	26		
BCFS San Antonio	Transitional Foster Care	119	•	•
BCFS Tornillo	Influx	665		•
Shiloh Treatment Center	Residential Treatment Center	23		•
SWK Antigua	Shelter	276		•
SWK Casa Houston	Shelter	71		•
SWK Montezuma	Shelter	209		•
SWK Casa Padre	Shelter	1,398		•
SWK Casa Quetzal	Shelter	246		•
SWK Casita del Valle	Shelter	84	•	•
SWK Combes	Shelter	73	•	•
SWK Mesa	Staff Secure	7		
SWK El Presidente	Shelter	372	•	•
SWK Nueva Esperanza	Shelter	290		•
SWK Processing Center	Staff Secure	16		
SWK Rio Grande	Shelter	225		•
Virginia (2)				
Shenandoah Valley Juvenile Center	Secure	20		•
Youth for Tomorrow	Shelter	111		•
Washington (2)				
Friends of Youth	Staff Secure	11		•
Selma Carson	Staff Secure	14		•

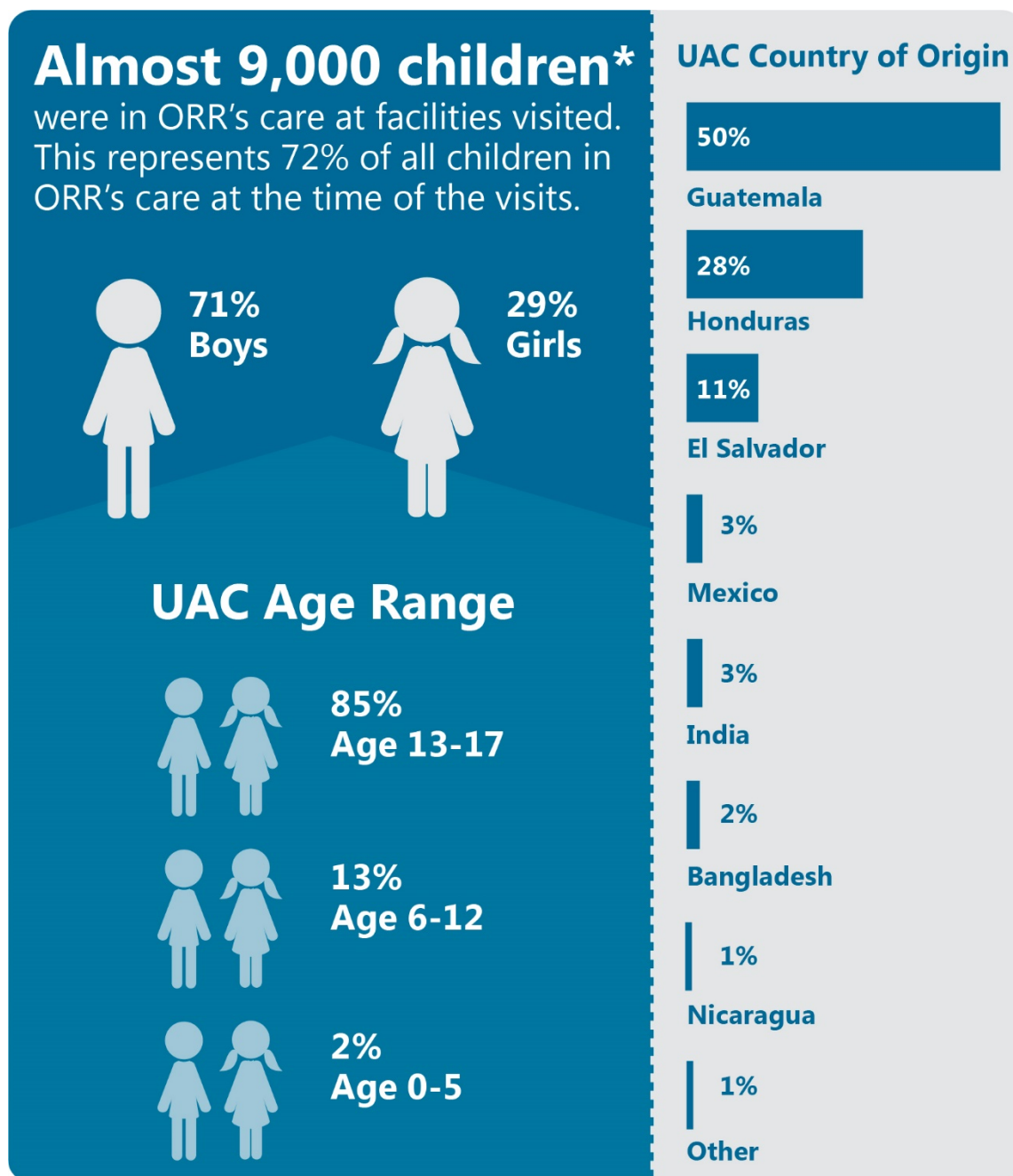
Source: OIG analysis of ORR and HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) data, 2019.

*Data on the number of children in care was as of August 30, 2018.

**Younger children include those who were 9 years old and under.

*** We obtained from ORR and ASPR data on separated children that were part of the *Ms. L v. ICE* lawsuit. Our analysis identified that 37 of the 45 facilities had children covered by the lawsuit.

Children's Demographics at Facilities Visited



Source: OIG analysis of ORR and facility data, 2019.

*According to ORR data, on August 30, 2018, 12,409 children were in ORR care. Of those, 8,953 children were at the facilities that OIG visited; the percentages of boys and girls are based on this number. The percentages on age range and country of origin are based on data collected directly from the facilities that we visited. We reviewed age and country of origin data that facilities provided to OIG. Because some facilities provided data for a point-in-time (i.e., specific date) while other facilities provided data over a specific timeframe (i.e., 3-month period), the total number of children between these two data points differs. Age range is based on data from 5,835 children; country of origin is based on data from 7,081 children. Because of rounding, the total percentage for country of origin does not add up to 100 percent.

APPENDIX B: Job Descriptions of Key Personnel

Below are job descriptions of individuals involved in the care and placement of children in facilities.³⁷

Program Directors. Program directors are senior facility staff who manage facility staff and oversee facility operations.

Medical Coordinators. Medical coordinators arrange care from external providers, coordinate other services related to children's medical and mental health care, and manage medication.

Mental Health Clinicians. Mental health clinicians are employed at every facility and are responsible for providing in-house mental health care for children in the facility. They conduct mental health assessments, provide counseling services, provide crisis intervention services, and recommend care from external providers. Lead mental health clinicians coordinate clinical services, train new mental health clinicians, and supervise staff.

Case Managers. Case managers coordinate assessments of children, individual service plans, and efforts to release children to sponsors. They also ensure that all services are documented in children's case files.

Youth Care Workers. Youth care workers provide around-the-clock monitoring of children. Youth care workers have direct and frequent contact with children and are the staff primarily responsible for their supervision.

ORR Federal Field Specialists. Federal field specialists are ORR employees who serve as local ORR liaisons to one or more facilities within a region. They are responsible for providing guidance and technical assistance to facilities and approving or denying children's transfer and release.

APPENDIX C: Related OIG Work

Information on OIG's work on this topic can be found on our [Unaccompanied Children webpage](#). Below is a list of OIG reports on unaccompanied children.

Title	Report Number	Date Issued
<u>Southwest Key Programs Did Not Always Comply With Health and Safety Requirements for The Unaccompanied Alien Children Program</u>	A-06-17-07005	August 2019
<u>Southwest Key Did Not Have Adequate Controls in Place To Secure Personally Identifiable Information Under the Unaccompanied Alien Children Program</u>	A-18-18-06001	August 2019
<u>The Children's Village, Inc., an Administration for Children and Families Grantee, Did Not Always Comply with Applicable Federal and State Policies and Requirements</u>	A-02-16-02013	April 2019
<u>Lincoln Hall Boys' Haven, an Administration for Children and Families Grantee, Did Not Always Comply with Applicable Federal and State Policies and Requirements</u>	A-02-16-02007	February 2019
<u>Separated Children Placed in Office of Refugee Resettlement Care</u>	OEI-BL-18-00511	January 2019
<u>BCFS Health and Human Services Did Not Always Comply With Federal and State Requirements Related to the Health and Safety of Unaccompanied Alien Children</u>	A-06-17-07007	December 2018
<u>The Tornillo Influx Care Facility: Concerns About Staff Background Checks and Number of Clinicians on Staff</u>	A-12-19-20000	November 2018
<u>Florence Crittenton Services of Orange County, Inc., Did Not Always Claim Expenditures in Accordance with Federal Requirements</u>	A-09-17-01002	October 2018
<u>Heartland Human Care Services, Inc., Generally Met Safety Standards, but Claimed Unallowable Rental Costs</u>	A-05-16-00038	September 2018
<u>Florence Crittenton Services of Orange County, Inc., Did Not Always Meet Applicable Safety Standards Related to Unaccompanied Alien Children</u>	A-09-16-01005	June 2018
<u>BCFS Health and Human Services Did Not Always Comply With Federal Requirements Related to Less-Than-Arm's-Length Leases</u>	A-06-16-07007	February 2018
<u>Office of Refugee Resettlement Unaccompanied Alien Children Grantee Review—His House</u>	A-04-16-03566	December 2017
<u>HHS's Office of Refugee Resettlement Improved Coordination and Outreach to Promote the Safety and Well-Being of Unaccompanied Alien Children</u>	OEI-09-16-00260	July 2017
<u>Division of Unaccompanied Children's Services: Efforts to Serve Children</u>	OEI-07-06-00290	March 2008

APPENDIX D: Use of Psychotropic Medications by Children in Care Provider Facilities Visited by OIG

In the 4 months before our visit, legal actions and press accounts alleged forced and otherwise improper use of medication by facilities.³⁸ Given the disturbing nature of the allegations and the potential for harm to children, we wanted to learn about any concerns that staff had about their facilities' use of psychotropic medications and any related challenges they faced. Therefore, we specifically asked facility personnel a series of questions related to use of psychotropic medications in each of the facilities we visited.

We collected information about psychotropic medications administered to children in the facilities that we visited. From each facility, we requested the number of children who had been prescribed a psychotropic medication during the 3-month period between May 1, 2018, and July 31, 2018, along with the name of each medication and the child's associated diagnosis. During interviews, we inquired about any challenges or concerns that program directors, mental health clinicians, or medical directors had related to the use of these medications. We also asked ORR federal field specialists about concerns they had about the facility's ability to manage medications. We did not independently review medical records or assess the appropriateness of any treatment or prescriptions.

Because the concerns and challenges that we heard were not widespread and involved a form of treatment provided to a relatively small number of children, we chose to address them in this Appendix, rather than in the body of the report, and we are making no formal recommendations. This choice was not meant to minimize the importance of the concerns and challenges that we heard, but instead reflects our approach of including only the most commonly voiced challenges as findings in the report.

The first section of this Appendix outlines the issues identified by facility management and staff and ORR field specialists related to use of psychotropic medications. The second section lists the most prevalent psychotropic medications that facilities reported had been prescribed to children in their care, and the corresponding health diagnoses.

Interview responses about use of psychotropic medications

A relatively small number of children in ORR custody had been prescribed a psychotropic medication. Between May 1, 2018, and July 31, 2018, only about 300 children (roughly 1 in 30, overall, in the facilities that we visited) had been prescribed a psychotropic medication. Mental health clinicians in most facilities (38 of 45), however, reported that they had some direct experience managing these medications.³⁹

The mental health clinicians, medical coordinators, program directors, and ORR federal field specialists whom we interviewed described the following issues concerning facilities' use of psychotropic medication.

Access to psychotropic medications. Facilities reported relatively few challenges accessing and administering psychotropic medications. Although program directors and health staff mentioned that they sometimes found it difficult to schedule appointments with external specialists who could prescribe and modify medications, children were able to receive needed medications. Some program directors noted that using telemedicine to access psychiatrists remotely helped bridge gaps in access.

Lack of clarity about authorization and consent for psychotropic medications to children.

A few program directors, medical staff, and an ORR federal field specialist described uncertainty about the process for obtaining authorization to treat children using psychotropic medications. ORR policy requires that an ORR staff member authorize children's use of prescription drugs to treat mental health conditions. However, facility staff reported that they were not always sure who within ORR needed to approve psychotropic medications; specifically, whether they needed to seek approval from their ORR federal field specialist or another ORR representative and whether parents' consent was required.

Confusion about authorization and consent may have been attributable, at least in part, to rulings by the *Flores* court regarding informed consent and varying State laws.⁴⁰ As of May 2019, ORR reported that it is working through the Department of Justice to try to negotiate a national framework for treatment authorization and consent for psychotropic medications with class counsel in *Flores*. ORR told us that if a facility notifies it that State law requires informed consent from parents before children use psychotropic medications, then ORR directs the facility to seek such consent, recognizing that this may not be possible or timely due to their inability to locate or establish communications with parents. If it is not possible to obtain parental consent in a timely way, then ORR may, depending on State law, direct the facility to seek a court order authorizing the use of psychotropic medications.

Medication refusal. A more common issue reported by facilities was children's reluctance to take psychotropic medications. Medical and mental health staff noted that stigma and medication side effects led some children to refuse psychotropic medications that were recommended as a part of their mental health treatment. According to staff accounts, children and their families did not always support treatment involving psychotropic medications. In some cases, they expressed a cultural stigma against psychotropic medications and mental health treatment, more generally. Medical and mental health staff also reported that some children experienced side effects, such as weight gain, drowsiness, and disrupted sleep, which led them to discontinue medications or request treatment changes. Facilities reported working with external prescribing physicians to adjust dosages to help manage side effects, and counseling children about the medications' expected benefits and potential side effects.

Concerns about treatment involving psychotropic medications. Although not widespread, we heard concerns about the use of psychotropic medications in facilities. Facility staff and ORR federal field specialists reported concerns that the particular medications or dosages prescribed by external specialists may not have been right for the children. In one instance, a lead mental health clinician in a secure facility questioned why a child was receiving anti-psychotic medication for help sleeping before other treatment methods were tried. In other cases, program directors, mental health clinicians, and medical coordinators questioned the number or dosage levels of psychotropic medications

that had been prescribed to children who transferred from other facilities in ORR's network. Conversely, a lead mental health clinician at a facility expressed the concern that a nurse practitioner would not prescribe psychotropic medications in cases when he and a psychiatrist recommended them. Our oversight of the program is continuing, and this area may warrant further review.

List of common psychotropic medications used and corresponding diagnoses

We collected a list of psychotropic medications used between May 1, 2018, and July 31, 2018, by children in the facilities that we visited. Below are the 10 psychotropic medications that the facilities most commonly reported. Facilities also reported the diagnoses or symptoms of the children taking these medications. Because some children, however, had more than one diagnosis or symptom, those listed below do not always reflect the primary treatment focus of the medication.

Prescribed Psychotropic Medication	Mental Health Diagnoses or Symptoms of Children in ORR Care Provider Facilities Taking the Medication.*	
Fluoxetine Brand name: Prozac	<ul style="list-style-type: none"> • Acute stress, anxiety & impulsivity • Adjustment disorder • Borderline personality traits • Disorganized thinking • Major depressive disorder 	<ul style="list-style-type: none"> • Mood disorder • Sleep disruption • Schizophrenia • Self-injurious behavior • Post-traumatic stress disorder (PTSD)
Hydroxyzine Brand name: Vistaril	<ul style="list-style-type: none"> • Adjustment disorder • Attention-deficit/hyperactivity disorder (ADHD) • Generalized anxiety disorder • Impulsive aggression 	<ul style="list-style-type: none"> • Major depressive disorder • Insomnia • Oppositional defiant disorder • PTSD
Risperidone Brand name: Risperdal	<ul style="list-style-type: none"> • Adjustment disorder • Bipolar disorder • Chronic irritability • Disruptive mood dysregulation disorder 	<ul style="list-style-type: none"> • Major depressive disorder • Schizophrenia • Sudden mood changes • Self-injurious behavior • Oppositional defiant disorder
Sertraline Brand name: Zoloft	<ul style="list-style-type: none"> • Generalized anxiety disorder • Major depressive disorder • Mood disorder • Panic disorder 	<ul style="list-style-type: none"> • Self-mutilating behaviors • Substance abuse • Suicidal ideation

(Continued on next page)

Medication	Mental Health Diagnoses or Symptoms of Children in ORR Care	
Trazodone Brand name: Desryl	<ul style="list-style-type: none"> • Adjustment disorder • ADHD • Disruptive, impulse-control, and conduct disorders • Generalized anxiety disorder 	<ul style="list-style-type: none"> • Major depressive disorder • Mood disorder • Panic attacks • Schizophrenia spectrum • Psychotic disorder
Escitalopram Brand name: Lexapro	<ul style="list-style-type: none"> • Anxiety disorder • Bipolar disorder • Major depressive disorder • Impulse-control disorder • Insomnia 	<ul style="list-style-type: none"> • Mood disorder • Oppositional defiant disorder • Substance abuse • Suicidal ideation • PTSD
Prazosin Brand name: Minipress	<ul style="list-style-type: none"> • Adjustment disorder • Disorganized thinking • Flashbacks of abuse • Insomnia 	<ul style="list-style-type: none"> • Major depressive disorder • Night terrors and nightmares • Panic attacks • PTSD
Mirtazapine Brand name: Remeron	<ul style="list-style-type: none"> • Adjustment disorder • Disruptive impulse-control and conduct disorder • Disruptive mood dysregulation disorder 	<ul style="list-style-type: none"> • Generalized anxiety disorder • Insomnia • Major depressive disorder • PTSD • Substance abuse
Guanafacine Brand name: Intuniv	<ul style="list-style-type: none"> • Adjustment disorder • ADHD • Impulse control disorder • Insomnia • Intermittent explosive disorder 	<ul style="list-style-type: none"> • Major depressive disorder • Mood disorder • Oppositional defiant disorder • Psychotic disorder • PTSD
Quetiapine Brand name: Seroquel	<ul style="list-style-type: none"> • Adjustment disorder • Bipolar disorder • Conduct disorder • Insomnia 	<ul style="list-style-type: none"> • Major depressive disorder • Mood affective disorder • Oppositional defiant disorder • Panic disorder

* These diagnoses and symptoms do not always reflect the primary treatment focus of the medication.

Source: OIG analysis of facility data, 2019.

APPENDIX E: Agency Comments



ADMINISTRATION FOR CHILDREN & FAMILIES

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August 7, 2019

Joanne M. Chiedi
Acting Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Ms. Chiedi:

The Administration for Children and Families (ACF) appreciates the opportunity to respond to the Office of Inspector General (OIG) report entitled, *Care Provider Facilities Described Challenges Addressing Mental Health Needs of Children in HHS Custody* (OEI-09-18-00431). ACF is committed to meeting the mental health needs of the unaccompanied alien children (UAC) in the care of the Office of Refugee Resettlement (ORR), and welcomes OIG's report as we work to continually improve ORR's delivery of mental health care to UAC.

ACF is equally committed to providing the public with a fair accounting of ORR program operations. To that end, we agree with OIG that significant factors beyond ACF's control contributed to the issues identified in the report. Those factors included: the surge of UAC that occurred during the period covered by the report; the unique mental health needs of UAC who experienced severe trauma prior to entering ORR's care; and the shortage of qualified, bilingual mental health clinicians, particularly in the rural areas where many ORR facilities are located.¹ Such context is critical to fairly assessing the mental health care delivered to UAC.

OIG was also correct to underscore the nature and scope of its methodology for the public. OIG performed a qualitative analysis of interviews with program directors, mental health clinicians, and medical coordinators. OIG also reviewed three selected case files from each of the 45 facilities visited, which it discussed with the assigned mental health clinician. We agree that this qualitative analysis provides the public and the program with helpful insights. Indeed, it corroborates that UAC generally receive all legally-required mental health care. It is not, however, a quantitative or clinical review that assesses the reasonableness of the mental health care delivered to UAC.

¹ See OEI-09-18-00431, at 11 ("The number of young children, age 12 and younger, in ORR's care increased sharply in May 2018 when DHS formally adopted the zero-tolerance policy of criminally prosecuting all adults for illegal entry into the U.S."); *id.* at 9 ("Facility managers and mental health clinicians reported that many children who entered facilities in 2018 had experienced intense trauma from a variety of events before and upon their arrival in the U.S."); *id.* at 14 ("Program directors reported difficulties in finding qualified candidates, especially those who were fluent in the languages spoken by children in their care. Program directors explained that these challenges were heightened for facilities in remote or rural areas, reflecting a shortage of mental health professionals in certain geographic regions.").

against standards of ordinary care or best clinical practices. This distinction is important given the complex mental health presentations of this young and vulnerable population.

As discussed more fully below, ACF has already taken steps to address many of the concerns identified in the report, such as the impact of length of stay in ORR facilities on child welfare. The average, system-wide length of stay reached a “high of 93 days for children who were released from ORR custody in November 2018”; in fact, “[b]y April 2019, the average length of stay had declined to 48 days,” which is significantly shorter than the 70-day concerns identified in the report. *See* OEI-09-18-00431, at 13 (“For example, one mental health clinician explained that even children who were outgoing and personable started getting more frustrated and concerned about their cases around the 70th day in care.”). Today, the discharge rate of children to sponsors are at some of their highest levels ever, which has a positive impact on length of stay.

In April 2019, a board-certified child, adolescent, and adult psychiatrist was hired by ORR to serve as the Mental Health Team Lead for ORR’s Division of Health for Unaccompanied Children (DHUC). Since the hiring, the psychiatrist is working to improve ORR’s mental health care system for UAC.

The following are ACF’s specific responses to OIG’s recommendations:

Recommendation 1: Identify and disseminate evidence-based approaches to addressing trauma in short-term therapy (p.18)

Response: ACF concurs with this recommendation.

In general, ORR’s goal for UAC is stabilization and fostering a sense of security. All UAC undergo a brief screening for trauma and its impact during intake. If a UAC displays trauma related symptoms or other mental health issues at any point in their care, they are assessed for specific psychiatric disorders by the appropriate medical or psychological providers and treated accordingly. ORR provides supportive therapy to facilitate UAC acclimation because the patient’s psychiatric baseline is needed to assess for specific psychiatric disorders, and is best observed once a patient is acclimated to his or her surroundings.²

ORR continues to work to improve upon this framework for delivering mental health care. Notably, ORR has collaborated with the National Center for Traumatic Stress Network (NCTSN) to develop a 4-part webinar series on trauma in unaccompanied alien children, including an overview of treating the effects of traumatic separation in young children. The webinars will cover: (1) Trauma 101, including assessment, cultural humility and competence when working with immigrant youth and families, and an overview of the migration journey and exposure to potentially traumatizing events; (2) a review of the research on trauma and psychoeducation specific to traumatic

² *See* Prins, A., Bovin, M.J., Kimerling, R., Kaloupek, D.G., Marx, B.P., Pless Kaiser, A., & Schnurr, P.P. (2015). Primary Care PTSD Screen for DSM-5 (PC-PTSD-5). *See also* Rousseau, C., Pottie, K., Thombs, B., et al. Post traumatic stress disorder: Evidence review for newly arriving immigrants and refugees. *Can. Med. Assoc. J.* 2011; Appendix 11.

separations, including how to recognize the effects of trauma/traumatic separation in youths seven and above; (3) recognizing Secondary Traumatic Stress (STS) in care providers, including recommendations for preventing and reducing STS at work; and (4) recognizing the effects of trauma/traumatic separation in youths ages six and under, working with children ages six and under, and an overview of the principles of attachment.

ORR anticipates launching the webinars in mid-August 2019. All UAC care providers will be required to participate in order to strengthen their understanding of how to effectively recognize and respond to children exhibiting signs of trauma. The webinars will be available through the NCTSN Learning Center. Upon successful completion of the series, participants will receive a certificate for the competency folder of their personnel file.

In addition, NCTSN has received supplemental appropriations UAC mental health services. ORR is working with NCTSN to identify training resources on evidence-based, brief therapeutic interventions for children affected by trauma and separation. ORR has proposed that NCTSN use its supplemental funding to strengthen the mental health services available to UAC after they are discharged from ORR custody. ORR has provided NCTSN with the list of post-release services (PRS) providers so that children who need ongoing mental health services after discharge can continue to receive these services.

ORR's continuing efforts to provide for the mental health needs of UAC even after they leave ORR's care is illustrated by the below statistics for home studies (HS) and PRS. PRS allow for UAC to be released to a sponsor and have their social integration, medical, and mental health needs attended to while under the supervision of their sponsor. Additionally, PRS case workers are able to meet with sponsors and released children on an ongoing basis to ensure the child's basic needs are met. If there are safety concerns the PRS case worker may notify ORR or local child protective services and law enforcement, as appropriate.

YEAR	HOME STUDIES	UAC SERVED BY PRS	NUMBER OF UAC RELEASED	RELEASE UAC WITH PRS
FY2018	3,641	14,088	35,249	40%
FY2017	3,173	13,381	42,729	31%
FY2016	3,540	10,546	52,661	20%
FY2015	1,895	8,618	28,289	22%

Post-release care helps address the inherent tension between ORR's goals of keeping children in ORR custody for the shortest period of time possible, and providing mental health treatment for

severe trauma, which can require more time than children will be in ORR care.³ There are simply fewer therapeutic interventions available to use with children who are in care for a relatively short period of time. *Mental health experts have noted that, in certain circumstances, there may be no suitable evidence-based approaches to addressing trauma in short-term therapy.* ACF urges OIG and the public to consider this important clinical limitation—and the critical role played by post-release care—when evaluating ORR’s delivery of mental health care to UAC.

Recommendation 2: Develop and implement strategies to assist care provider facilities in overcoming obstacles to hiring and retaining qualified mental health clinicians (p.19)

Response: ACF concurs with this recommendation.

As the report recognizes, there are significant external challenges to hiring and retaining qualified mental health clinicians. In addition to “demanding work schedules[] and competing job opportunities,” “[p]rogram directors reported difficulties in finding qualified candidates, especially those who were fluent in the languages spoken by children in their care. Program directors explained that these challenges were heightened for facilities in remote or rural areas, reflecting a shortage of mental health professionals in certain geographic regions.” OEI-09-18-00431, at 14. Public misinformation about ORR’s UAC program has exacerbated the challenges to recruitment. Faced with these challenges, ORR is currently working on several strategies to improve the hiring and retention of qualified mental health clinicians.

First, ORR is working to develop an internship program that partners with colleges and universities in order to place interested students in ORR programs. ORR’s goal is to create a standardized process with clearly defined requirements through which interested students can obtain a one-year internship at any ORR facility. Although some ORR grantees already have partnered with colleges and universities to provide internship opportunities, expanding and standardizing the internship program across the ORR network would create a direct pipeline between new professionals in the field and ORR.

Second, ORR has made additional funding for continuing education available to licensed clinicians as a retention strategy.

Third, ORR is working to expand its presence at job fairs in geographic regions where there is particular need to hire additional mental health clinicians.

Recommendation 3: Assess whether to establish maximum caseloads for individual mental health clinicians (p.19)

Response: ACF concurs with this recommendation.

³ As the report recognizes, “mental health clinicians did not know how long a child would be in their facility” and were “wary of having children revisit traumatic incidents that they might not be able to address adequately through continued therapy.” OEI-09-18-00431, at 9–10.

ORR plans to evaluate the one to twelve ratio of mental health clinicians to children in consultation with internal HHS and external subject matter experts. ORR will review subject matter recommendations in concert with an evaluation of barriers to hiring and retaining staff identified in the response to recommendation 2. Additionally, ORR will consider varying clinical ratios dependent on facility type and whether a care provider serves a special population that may be in need of smaller clinical ratios. ORR's goal is to ensure children are provided quality mental health counseling and that care providers are given sufficient support to serve children in ORR care and custody.

Recommendation 4: Help care provider facilities improve their access to mental health specialists (p.20)

Response: ACF concurs with this recommendation.

Unfortunately, there is a national shortage of qualified mental health professionals—especially where the additional language requirement is concerned.⁴ The effects of this national shortage are particularly acute for those “facilities . . . in underserved areas with relatively few practicing specialists.” OEI-09-18-00431, at 14. Despite these challenges, ORR and its care provider facilities have achieved success relative to the national trend, in that the children in ORR custody have significantly greater access to mental health professionals than those in the United States but who are not in ORR custody, particularly in the states where the 45 grantee facilities are located.⁵

Since 2004, it has been standard practice for ORR to allow care providers to seek services from out-of-network providers in their community, if no ORR facility meets the needs of a child in ORR care. Both the previous agency that provided underwriting services to ORR (the Department of Veterans Affairs), and the current underwriter, Point Comfort Underwriters (PCU), have been very open to helping ORR meet any unmet mental health needs of UACs through out-of-network providers.

DHUC works with PCU to identify mental health providers in geographic locations with few resources, including hospitals, non-profit mental health clinics, and individual providers. DHUC also seeks behavioral telehealth providers, whose practices have a farther reach than traditional in-person treatment providers.

In addition to routine psychiatric and psychological evaluation and follow-ups, services include specialized treatment, such as trauma-focused cognitive behavioral therapy and dialectical behavior therapy. Specialized care is also being sought out for the ORR network, such as intensive outpatient programs (IOP) and partial hospitalization programs (PHP), both of which are intended to be utilized when routine outpatient services have been insufficient to meet the needs of UAC in ORR care. ORR hopes that greater access to specialized care will obviate the need for longer-term and more restrictive settings, such as residential treatment centers (RTC).

⁴ See <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁵ *Id.*

Recommendation 5: Increase therapeutic placement options for children who require more intensive mental health treatment (p.20)

Response: ACF concurs with this recommendation.

Prior to placing a child in a higher level of care, ORR recommends there be a discussion using the case consultation program in order to mitigate the use of intensive mental health treatment. ORR's case consultation program involves a multi-disciplinary team comprised of staff of varying expertise and programmatic experience who help analyze complex cases and make recommendations regarding care. The team includes senior ORR personnel, ORR medical professionals, senior Federal Field Specialists (FFS), and other subject matter experts.

In addition, ORR has hired a Field Supervisor for Special Populations to oversee care and treatment services for UAC in secure, staff secure, and RTC placements. This position's responsibilities have expanded to include seeking and coordinating increased mental health and treatment services for shelter cases needing specialized placement.

Due to the limited number of beds for children with greater mental health needs in the ORR network, coupled with the surge of UAC, ORR has experienced an increased need for additional therapeutic programs for the UAC population. ORR has engaged several out-of-network therapeutic facilities to aid in providing treatment for UAC, such as Acadia, Devereux, The Farm Trillium, Laurel Ridge, Indian Oaks, and NY Children's Hospital, as well as existing ORR grantees, KidsPeace and Youth for Tomorrow. Acadia has several RTC and sub-acute hospitals within the United States that have been utilized to help with ORR's population requiring unique care. Additionally, efforts have been made to engage new partners to further support this special population.

Unfortunately, adverse media coverage and negative public perception of the UAC program have hampered efforts to expand ORR's network of treatment providers. For instance, one of Acadia's programs, Detroit Behavioral Institute, opted out of becoming an in-network facility after beginning the process of joining the ORR care network due to concerns over negative media coverage and possible legal liability. Out-of-network providers also have cited language barriers and the requirements of *Flores* and the Trafficking Victims Protection Reauthorization Act as additional challenges they are not equipped to handle.

As discussed above, DHUC is working to expand access to higher levels of mental health care, such as IOP and PHP.

Lastly, DHUC has developed and delivered trainings for FFS on the appropriate use of RTC. It is emphasized that UAC should first be referred to appropriate outpatient services, and only when these services are exhausted or unavailable should referral to an RTC be considered, provided the referral criteria set forth in ORR Guide § 1.4.6 are met. DHUC also consults with shelter, staff secure, and secure facilities on these issues.

Recommendation 6: Take all reasonable steps to minimize the time that children remain in ORR custody (p.20)

Response: ACF concurs with this recommendation.

ACF has already taken reasonable steps to accelerate discharges to safe, suitable sponsors, which has helped to greatly reduce the average time that UAC stay in ORR's care and custody. The report recognizes that those efforts resulted in system-wide average lengths of stay in April 2019 that were more than 48 percent below the "high of 93 days for children who were released from ORR custody in November 2018." OEI-09-18-00431, at 13. The average time UAC now spend in ORR care has decreased from more than 93 days in November 2018, to 45 days in July 2019.

ORR continuously evaluates its policies, procedures, and operations to align with best practices in child welfare, and to achieve an optimal balance between safe and timely discharge of UAC to sponsors. In late 2018, ORR reviewed the effects of expanded biometric background checks, per the ORR-ICE-CBP Information Sharing Memorandum of Agreement (MOA) of April 2018. The purpose of this review was to assess whether or not the new biometric background check procedures under the MOA yielded new information that enabled ORR to identify child welfare risks that it would not have found under prior policy. ORR also examined whether a correlation existed between the expanded biometric background checks and UAC length of stay.

Following that assessment, between December 2018 and June 2019, ORR issued four operational directives that modified its sponsor suitability assessment process to optimize the balance between child safety and timely discharge to sponsors. Under the operational directives, ORR now completes individualized suitability assessments of sponsors without obtaining fingerprints from all household members, or all parents or legal guardians or certain close relatives in appropriate cases. ORR also permits, under certain circumstances, the release of children to other relatives who were their primary caregivers prior to receiving the results of a fingerprinting background check. Within 180 days of issuing the fourth operational directive, ORR will complete a full evaluation of its implementation, including any correlation with reduced length of stay.

Congress has prohibited HHS from using funds provided in the Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act, 2019 (Pub. L. 116-26) or previously appropriated funding to reverse the procedures of the first three operational directives, unless the Secretary of Health and Human Services determines that a change is necessary to protect a child from being placed in danger. The HHS Secretary is required to submit the justification for the change in writing to the Office of Inspector General and to Congress prior to implementation of a proposed change.

The Act also requires HHS to submit a discharge rate improvement plan to Congress. That plan will set forth our future strategies for optimizing our discharge rate.

Again, thank you for the opportunity to review this report. As detailed above, ACF is already implementing many of the report's recommendations. ACF takes its responsibility to care for UAC very seriously, and looks forward to continuing to work to improve the mental health services

The Acting Inspector General
Page 8

it provides. Please direct any follow-up inquiries on this response to Scott Logan, Office of Legislative Affairs and Budget, at (202) 401-4529.

Sincerely,



Lynn A. Johnson,
Assistant Secretary
for Children and Families

ACKNOWLEDGMENTS

Camille Harper served as team leader for this study. Other Office of Inspector General staff who conducted the study and were primary contributors include Chelsea Samuel and Diana Merelman. Key advisors included Laura Canfield, Abigail Cummings, and Carla Lewis, with support from Lyndsay Patty and Seta Hovagimian.

We would also like to acknowledge other significant contributors without whom this effort would not have been successful. Staff from each Office of Inspector General component contributed, including the Office of Audit Services, the Office of Counsel, the Office of Evaluation and Inspections, the Office of Investigations, and the Office of Management and Policy. Contributions included planning and conducting fieldwork, data and administrative support, and report production and distribution.

This report was prepared under the direction of Blaine Collins, Regional Inspector General for Evaluation and Inspections.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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ENDNOTES

¹ Charles D. R. Baily, et al. "The Psychosocial Context and Mental Health Needs of Unaccompanied Children in United States Immigration Proceedings," *Graduate Student Journal of Psychology*, Vol. 13, 2011, p. 4. Accessed at https://www.tc.columbia.edu/publications/gsjp/gsjp-volumes-archive/gsjp-volume-13-2011/19225_V13_1_Baily.pdf on July 17, 2019.

² 6 U.S.C. § 279(g)(2).

³ *Flores v. Reno*, No. 85-4544 (C.D. Cal. Jan. 17, 1997). This Stipulated Settlement Agreement sets out an order of priority for sponsors with whom children should be placed. The first preference is for placement with a parent, followed by a child's legal guardian, then other adult relatives. In fiscal year 2018, 42 percent of children released to sponsors were released to a parent. *Ms. L v. ICE*, No. 18-0428. (S.D. Cal. Feb. 1, 2019) (Declaration of Jonathan White).

⁴ 6 U.S.C. § 279(g)(2), in part, defines UAC as a child who "has not attained 18 years of age." Also see, Office of Refugee Resettlement, *ORR Guide: Children Entering the United States Unaccompanied* (ORR Guide), Introduction. Accessed at <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-0> on July 17, 2019.

⁵ HHS, ACF, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2020, pp. 6, 38. Accessed at https://www.acf.hhs.gov/sites/default/files/olab/acf_congressional_budget_justification_2020.pdf on July 17, 2019. DHS referred 49,100 children to ORR in 2018.

⁶ Based on OIG analysis of ORR data, as of August 13, 2018.

⁷ 8 U.S.C. § 1232(c)(2)(A).

⁸ ORR Guide, § 1.4.6, Residential Treatment Center Placements. Accessed at <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1> on July 17, 2019.

⁹ *Flores v. Reno*, No. 85-4544 (C.D. Cal. Jan. 17, 1997) (Stipulated Settlement Agreement).

¹⁰ ORR Guide, § 3.2.1, Admissions for Unaccompanied Alien Children. Accessed at <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-3#3.2.1> on July 17, 2019.

¹¹ ORR Guide, § 3.3.1, UAC Assessment and Case Review. Accessed at <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-3#3.3.1> on July 17, 2019.

¹² ORR Guide, § 3.3: Care Provider Required Services. Accessed at <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-3#3.1> on July 17, 2019.

¹³ ORR Guide, § 1.7.5, Medical Services. Accessed at <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1> on April 19, 2019. Also see, *The Tornillo Influx Care Facility: Concerns About Staff Background Checks and Number of Clinicians on Staff*, A-12-19-20000, Nov. 27, 2018, available at <https://oig.hhs.gov/oas/reports/region12/121920000.pdf>, which discusses the mental health staffing at Tornillo and Homestead, the two influx facilities in operation during the period of OIG's review.

¹⁴ Cooperative Agreement Between HHS and [Grantee Facility] § IV.C.1. ORR may grant waivers to the 1:12 ratio.

¹⁵ Cooperative Agreement Between HHS and [Grantee Facility] § IV.C.7.

¹⁶ Cooperative Agreement Between HHS and [Grantee Facility] § IV.C.7. Lead Clinicians with a bachelor's degree (but not a master's degree) must have at least 5 years of clinical employment experience in the behavioral sciences.

¹⁷ Ibid. If the size of the facility does not justify a full-time medical coordinator, those duties may be combined with another position.

¹⁸ The zero-tolerance policy, signed by the Attorney General on April 6, 2018, directed prosecutors “in consultation with DHS—to adopt immediately a zero-tolerance policy” for all illegal entry. *Memorandum for Federal Prosecutors Along the Southwest Border: Zero-Tolerance for Offenses Under 8 U.S.C. § 1325(a)*. Office of the Attorney General, April 6, 2018. Accessed at <https://www.justice.gov/opa/press-release/file/1049751/download> on July 17, 2019. DHS began implementing this policy with respect to family units in early May 2018.

¹⁹ Exec. Order 13841, 83 Fed. Reg. 29435, dated June 20, 2018, and published on June 25, 2018; *Ms. L v. ICE*, No. 18-0428 (S.D. Cal. June 26, 2018) (Order Granting Plaintiffs’ Motion for Classwide Preliminary Injunction).

²⁰ In January 2019, OIG found that the number of separated children placed in ORR care as a result of increased immigration enforcement by DHS was unknown. In addition to 2,737 separated children of *Ms. L v. ICE* class members who were in ORR care as of June 26, 2018, HHS officials estimated that thousands of additional children may have been separated by DHS, transferred to ORR care, and released through normal procedures during an increase in separations that began in 2017, before the accounting required by the Court and nearly a year before the zero-tolerance policy was announced. Additionally, some separations continued after the court order. HHS OIG Issue Brief, *Separated Children Placed in Office of Refugee Resettlement Care*, OEI-BL-18-00511, January 2019, available at <https://oig.hhs.gov/oei/reports/oei-BL-18-00511.pdf>.

²¹ As of December 2018, ORR discontinued the requirement that non-sponsor adult household members undergo fingerprint background checks in every circumstance. In March 2019, ORR discontinued the FBI fingerprint requirement for parents and legal guardians in every circumstance.

²² Memorandum of Agreement Among the Office of Refugee Resettlement of the U.S. Department of Health and Human Services and U.S. Immigration and Customs Enforcement and U.S. Customs and Border Protection of the U.S. Department of Homeland Security Regarding Consultation and Information Sharing in Unaccompanied Alien Children Matters, April 13, 2018.

²³ Section 224 of the Consolidated Appropriations Act, 2019 (P.L. 116-6), which was enacted into law on February 15, 2019, prohibits DHS from bringing enforcement actions against a sponsor, a potential sponsor or members of a household of a sponsor or potential sponsor based on data provided by HHS unless the background check reveals a felony conviction or pending felony charge, among other exceptions. Unless extended, this prohibition may expire on September 30, 2019. (See, e.g., *Williams v. United States*, 240 F.3d 1019, 1063 (Fed. Cir. 2001); 65 Comp. Gen. 588; B-230110, Apr. 11, 1988; B-228838, Sept. 16, 1987; B-145492, Sept. 21, 1976.)

²⁴ *Unaccompanied Alien Children Care Provider Facilities Generally Conducted Background Checks but Faced Challenges in Hiring, Screening, and Retaining Employees*, A-12-19-20001.

²⁵ In addition to interviews with lead clinicians at each of the 45 facilities, we conducted 123 case study reviews with 96 clinicians (some of whom may have been lead clinicians).

²⁶ If the individual who held the position was not available, we interviewed the staff member acting in that capacity at the facility.

²⁷ Each ORR federal field specialist may oversee multiple facilities. As such, a federal field specialist may have been interviewed multiple times regarding different facilities.

²⁸ As detailed in *Unaccompanied Alien Children Care Provider Facilities Generally Conducted Background Checks but Faced Challenges in Hiring, Screening, and Retaining Employees*, A-12-19-20001, OIG reviewed 1,050 employee files from the 45 facilities we visited during August and September 2018. Only 5 of the 173 clinicians included in our review did not meet minimum educational requirements. Of these, three mental health clinicians had a bachelor’s degree, but their employee file did not support the required 5 years of clinical experience. OIG found only one clinician with no relevant degree or experience and one

clinician whose employee file did not contain educational records or a diploma documenting a degree.

²⁹ *Duchitanga v. Hayes*, No. 1:18-cv-10332-PAC (S.D.N.Y. May 15, 2019) (Declaration of Jalynn Sualog).

³⁰ See Endnotes 22 and 23. Also see, 83 Fed. Reg. 20844 (May 8, 2018) (DHS' system of records notice for the collection and maintenance of records for background checks to inform an HHS determination regarding sponsorship of a UAC and to use this information for other purposes consistent with its statutory authorities).

³¹ More than half of facilities (26 of 45) reported that their clinician positions were the most difficult positions to fill.

³² H. Andrilla, MS et al., "Geographic Variation in the Supply of Selected Behavioral Health Providers," *American Journal of Preventive Medicine*, Vol 54(6), Pg. S199-S207.

³³ Four facilities reported in-house mental health specialists, including a psychologist (shelter), psychiatrist (RTC and secure facility), and psychiatric nurse practitioner (transitional foster care facility). Three additional facilities reported employing other medical practitioners.

³⁴ As noted earlier, ORR is legally required to house children in the least restrictive setting that is appropriate for the child among its continuum of care provider facility types. That determination may change over time, necessitating transfer of a child to a more or less restrictive setting. See ORR Guide, § 1.4, Transfers Within the ORR Care Provider Network. Accessed at <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1#1.4.6> on July 17, 2019.

³⁵ On March 1, 2019, 15 children in ORR custody were in non-ORR placements.

³⁶ ORR Guide, § 1.4.6: Residential Treatment Center Placements. Accessed at <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-section-1#1.4.6> on July 17, 2019.

³⁷ Position descriptions are summarized from the ORR Guide: Guide to Terms, Accessed at <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied-guide-to-terms>, on July 17, 2019; and the Cooperative Agreement between HHS and [Grantee Facility] § IV. C.7.

³⁸ *Jenny L. Flores, et al. v. Jefferson B. Sessions, III, et al.*, CV-85-4544 DMG (AGRx) (C.D. Cal. July 30, 2018) (Order Re Plaintiffs' Motion to Enforce Class Action Settlement); *Lucas R., et al. v. Alex Azar and E. Scott Lloyd* (C.D. Cal. June 29, 2018) (Complaint for Injunctive Relief); "Forced Drugging: Migrant Children's Accounts" *Reveal*, June 22, 2018 accessed at <https://www.revealnews.org/blog/forced-drugging-migrant-childrens-accounts/> on July 17, 2019; "Immigrant Shelters Drug Traumatized Teenagers Without Consent," *ProPublica*, July 20, 2018; accessed at <https://www.propublica.org/article/immigrant-shelters-drug-traumatized-teenagers-without-consent> on July 17, 2019.

³⁹ Of the 45 facilities we visited, 38 either reported during interviews that they cared for a child who was prescribed psychotropic medications or separately shared information about psychotropic medications that had been prescribed to children in their facilities between May 1, 2018, and July 31, 2018.

⁴⁰ A July 30, 2018 order from the *Flores* court addressed the consent requirements that Texas-based care provider facilities must follow when dispensing psychotropic medications to UAC. According to ORR, before the implementation of the July 30, 2018, order, ORR Federal staff provided informed consent as the Federal custodian of children in Texas facilities. After the order, ORR informed facilities in Texas that they must instead obtain consent from a parent, close relative, or other person authorized by court order to give consent. However, Texas licensing authorities have since indicated that ORR, as the Federal custodian, should continue to give informed consent. Other States vary in how they apply their licensing laws and regulations to the ORR grantees that provide care to children. For example, in Arizona, the medical authorization of the ORR Director, as well as the clinical judgment of treating clinicians, is considered sufficient documentation and protocol for prescribing medications.